Appointment of Personal Representative

Patient Name: ________________________________ Date of Birth: ____________________

Purpose

This form allows you (the "Patient") to give Foothill Family Clinic permission (authorization) to disclose your protected health information (PHI) to a person that will act as your Personal Representative. The information covered by this authorization is protected health information, including identification of treating providers of care, diagnoses, procedures, and personal information such as your date of birth and mailing address.

Each adult family member, including each adult child (age 18 or older) who wishes to name a Personal Representative must complete an authorization form. For example, if you expect your spouse to call us on your behalf, you need to fill out this form. If you do not wish to name a Personal Representative, do not complete this form. You are not required to name a Personal Representative, but if you do not, we will not release your protected health information to someone who may call or write on your behalf. Your Personal Representative may be anyone of your choosing, such as a spouse, parent, child, friend, congressperson or union representative. You must provide the information requested below for each person before we can treat that person as your Personal Representative. If you need additional forms, you may copy this form or call us.

Please Note: This authorization does not give your Personal Representative authority, either implied or direct, over any treatment or direct care decisions.

Authorized Use and/or Disclosure

I understand that Foothill Family Clinic's privacy practice is to not disclose my personal health information except for the purpose of treatment, payment and health care operations, or as required by law, without my written authorization. For this reason, I authorize you to disclose my protected health information to the person(s) named below for the purpose of assisting with or facilitating my health care and payment of any health benefits. Unless I have stated otherwise in Restrictions, I also allow my Personal Representative the following rights: the right to request amendment of my PHI; the right to request an accounting of disclosures of my PHI; and the right to request restrictions on disclosure of my PHI. I understand that if my Personal Representative is not a health plan, a health care provider, or another entity subject to federal or applicable state privacy laws, those laws may no longer protect my personal health information, and my Personal Representative may further disclose my protected health information without my authorization. I acknowledge that my authorization is voluntary.

I understand that I have the right to limit the information you release under this authorization. For example, I may limit a Personal Representative's access to information only about a particular provider or diagnosis/disease; or I may allow a Personal Representative access to everything except information from a particular provider or about a particular diagnosis/disease. Any such limitations must be described in Restrictions in this section.

Personal Representative 1 *(Please Print Clearly)*

Full Name: ____ Phone Number: _________________________

Relationship to You: ____________________ (such as: spouse, parent, child, friend, etc.) Date of Birth: ____________________

Restrictions: ____

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Issued: April 1, 2003
Revised: N.A.

Personal Representative 2 *(Please Print Clearly)*

Full Name: ____ Phone Number: ________________________

Relationship to You: ___________________ (such as: spouse, parent, child, friend, etc.) Date of Birth: ___________________

Restrictions: ____

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This authorization to release information to my Personal Representative will automatically expire in three (3) years after the date of my last visit to Foothill Family Clinic.

I understand that I have the right revoke or end this authorization at any time. I understand that, if I do not wish any person named above to remain my Personal Representative, I must revoke my authorization by giving written notice of my decision to the Privacy Official at the address shown below. I understand that my revocation of this authorization will not affect any action that has been taken or information that has already been released, based upon this authorization, before receiving my request to revoke authorization.

Privacy Officer
Foothill Family Clinic North
2295 S Foothill Drive
Salt Lake City, UT 84109
(801) 486-3021

Privacy Officer
Foothill Family Clinic South
6360 South 3000 East, Suite 100
Salt Lake City, UT 84121
(801) 365-1032

I, ____, have had full opportunity to read and consider the content of this form. I understand that by signing this form, I am confirming my authorization that Foothill Family Clinic may disclose my protected health information to the person(s) named on this form, for the purpose described above.

Signature: ____ Date: ______________________________

Complete and sign this form. You are entitled to a copy of this complete form.